



Children's Mental Health Waiver ISP Behavior Support Plan

Name of Youth: _____

Service Plan Date: _____

Name/Title of Team Member responsible for monitoring/reporting:

Start Date: _____

What is the specific behavior(s) or situation(s) this behavior support plan has been designed to address.

What does the child/youth do well in this area? What skills or attitudes does the family and/or youth have to help cope or deal with this behavior?

What does the youth need to do instead?

How are we going to teach the desired behavior:

What will be the reward for exhibiting the desired behavior?

Are there any safety concerns relating to the plan to change this behavior?

What is the parent, team member, or others going to do if the behavior causes or is going to cause physical harm to the youth or others?

If the behavior occurs and the steps in the plan are not working, what needs to happen to calm the situation and/or keep everyone (youth, family, others) safe?

Responsible Team Member

Date

Reviewer (Mental Health Provider)

Date

Youth/Family Member Initials _____

Family Care Coordinator Initials _____

I have reviewed, understand and agree to follow this plan:

Copies of data collection forms must be submitted to the Family Care Coordinator by the 10th day of the next calendar month following service delivery until the outcome has been met or discontinued.